Initial Approval: October 11, 2017

CRITERIA FOR PRIOR AUTHORIZATION

Ocrevus™ (ocrelizumab)

PROVIDER GROUP Professional

MANUAL GUIDELINES The following drug requires prior authorization:
Ocrelizumab (Ocrevus®)

CRITERIA FOR APPROVAL (must meet all of the following):

- Patient must have a diagnosis of relapsing or primary progressive forms of multiple sclerosis (MS) (i.e., RRMS or PPMS)
- Patient must be 18 years of age or older
- Must be prescribed by or in consultation with a neurologist
- Patient must not have active hepatitis B virus (HBV), confirmed by positive results for HBsAg and anti-HBV tests
- Must not be using with other disease modifying agents (DMA) for MS

LENGTH OF APPROVAL: 12 months

Notes:

- Recommended dosing: Initial dose: 300 mg intravenous infusion, followed two weeks later by a second 300 mg intravenous infusion. Subsequent doses: single 600 mg intravenous infusion every 6 months.
- Prior to initiating OCREVUS, perform Hepatitis B virus (HBV) screening. OCREVUS is contraindicated in patients with active HBV confirmed by positive results for HBsAg and anti-HBV tests. For patients who are negative for surface antigen [HBsAg] and positive for HB core antibody [HBcAb+] or are carriers of HBV [HBsAg+], consult liver disease experts before starting and during treatment.
- Administer pre-medication (e.g., methylprednisolone or an equivalent corticosteroid, and an antihistamine) to reduce the frequency and severity of infusion reactions. The addition of an antipyretic (e.g., acetaminophen) may also be considered.
- Administer all necessary immunizations at least 6 weeks prior to treatment initiation.

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DRUG UTILIZATION REVIEW COMMITTEE CHAIR	PHARMACY PROGRAM MANAGER DIVISION OF HEALTH CARE FINANCE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
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DATE	DATE